THIS ISSUE

Recent Changes to the Medical Aid Rules

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On The Internet:
Visit Health Services Analysis' website to view all Provider Bulletins currently in effect at www.wa.gov/lni/hsa/hsa_pbs.htm

Purpose

The purpose of this update is to communicate recent revisions to the *Medical Aid Rules*. These changes to the Washington Administrative Code (WAC) impact both State Fund claims and Self-Insured claims. The text of these updated WAC's is included for your complete understanding of the changes and so that you may insert them into your copy of the *Medical Aid Rules*.

Summary of changes:

(1) Definition of "proper and necessary" health care services (effective 1/8/2000)
WAC amended: WAC 296-20-01002

One definition within this WAC was rewritten to more clearly describe what treatment limitations already exist under Title 51, the Industrial Insurance Act.

What has changed?

- "Medically necessary" health care services was renamed "proper and necessary" health care services to be consistent with terminology used in RCW 51.36.010.
- Within the definition of "proper and necessary," we clarified what is meant by curative and rehabilitative treatment. Additionally, payment limitations are now described in terms of "maximum medical improvement" as well as "fixed and stable." This clarifying language will not change what treatment injured and ill workers are entitled to.
- All the defined terms in this WAC are now alphabetized.

(2) Provider reporting requirements (effective 1/24/2000)
WAC amended: WAC 296-20-06101

Provider reporting requirements were reviewed in response to Governor Locke's Executive Order 97-02 on regulatory improvement and evaluated to see whether they are still valid.

What has changed?

- No new reporting requirements were added or deleted.
- The existing WAC was reformatted using tables to make the reporting requirements easier to understand.

(3) Criteria for medical coverage decisions (effective 1/8/2000)
WAC's created: WAC 296-20-02700 through WAC 296-20-02705, and WAC 296-20-02850

These new WAC sections describe criteria used by the department to make medical coverage decisions. A medical coverage decision is a general policy decision to include or exclude a specific health care service or supply as a covered benefit.

(4) Drug coverage rules (effective 1/20/2000)
WAC amended: WAC 296-20-030
WAC repealed: WAC 296-20-03003
WAC's created: WAC 296-20-03010 through WAC 296-20-03024

What has changed?
The drug coverage rules were rewritten to be clearer and easier to understand. In addition, portions of previous WAC 296-20-03003 contained obsolete drug information or had become inconsistent with current prescribing practices.

Some specific changes include:

- A reference to the department's new outpatient drug formulary,
- Expanded coverage for injectable drugs postoperatively up to 48 hours from the time of discharge,
- Specific exceptions for patients with cancer (or other end-stage disease) or spinal cord injuries, and
- Expanded coverage for opioids to treat chronic, noncancer pain.

Opioids for chronic, noncancer pain:

In accordance with the new administrative rules (WAC's) on the payment for opioids to treat chronic, noncancer pain, the treating physician is required to submit two new reports and a treatment agreement. Please review the table below to see, at a glance, more information about this required documentation. Copies of the Opioid Progress Report Supplement and Functional Progress Form follow the tables. You can obtain these new forms from your local Labor and Industries office or on the Internet at www.wa.gov/lni.

In addition to the WAC's and department forms attached to this document, please look for a comprehensive Provider Bulletin on this issue in February of 2000. The February Provider Bulletin will include the following:

- Treatment guidelines for outpatient prescription of oral opioids for injured workers with chronic, noncancer pain. These guidelines were developed by the Washington State Department of Labor & Industries in collaboration with the Washington State Medical Association (WSMA) Industrial Insurance and Rehabilitation Committee;
- A sample Opioid Treatment Agreement; and
- A self-assessment test for 2 hours of CME credit.

When treating chronic noncancer pain with opiods, these reports are needed in addition to the regular 60-day reports:

Point in opioid treatment	Type of Report	For details see:	Frequency of Report	Billing code	Paid amount
Initiating treatment with opioids for chronic, noncancer pain	**1. Initial report documenting the need for opioid treatment*** (narrative)	1. WAC 296-20-03020	*All three reports are needed at the initiation of treatment for chronic, noncancer pain	1. 1064M	$27.03
	2. Opioid Progress Report Supplement -for baseline measurements of pain/function (department form) *F245-359-000*	2. WAC 296-20-03021 WAC 296-20-03022 Attached form		2. 1057M	$12.78
	3. Treatment agreement	3. Opioid Provider Bulletin in February of 2000 or on the Internet at www.lni.wa.gov/omd/opioids			
Ongoing treatment	**1. Opioid Progress Report Supplement** (department form) *F245-359-000*	1. WAC 296-20-03021 WAC 296-20-03022 Attached form	1. At least every 60 days	1. 1057M	$12.78
	2. Functional Progress Form (department form) F245-363-000	2. Attached form	2. Voluntary		
	3. Treatment agreement	3. Opioid Provider Bulletin in February of 2000 or on the Internet at www.lni.wa.gov/omd/opioids	3. Every six months		

* No later than thirty days after the attending physician begins treating the worker with opioids for chronic, noncancer pain, the attending physician must submit a written report to the department or self-insurer in order for the department or self-insurer to pay for such treatment. (See WAC 296-20-03020 for details.)

WAC 296-20-01002 Definitions

Acceptance, accepted condition: Determination by a qualified representative of the department or self-insurer that reimbursement for the diagnosis and curative or rehabilitative treatment of a claimant's medical condition is the responsibility of the department or self-insurer. The condition being accepted must be specified by one or more diagnosis codes from the current edition of the International Classification of Diseases, Clinically Modified (ICD-CM).

Attendant care: Those personal care services that assist a worker with dressing, feeding, and personal hygiene to facilitate self-care and are provided in order to maintain the worker in their place of temporary or permanent residence consistent with their needs, abilities, and safety. These services may be provided by but are not limited to, registered nurses, licensed practical nurses, registered nursing assistants, and other individuals such as family members.

Attending doctor report: This type of report may also be referred to as a "60 day" or "special" report. The following information must be included in this type of report. Also, additional information may be requested by the department as needed.

(1) The condition(s) diagnosed including ICD-9-CM codes and the objective and subjective findings.

(2) Their relationship, if any, to the industrial injury or exposure.

(3) Outline of proposed treatment program, its length, components, and expected prognosis including an estimate of when treatment should be concluded and condition(s) stable. An estimated return to work date should be included. The probability, if any, of permanent partial disability resulting from industrial conditions should be noted.

(4) If the worker has not returned to work, the attending doctor should indicate whether a vocational assessment will be necessary to evaluate the worker's ability to return to work and why.

(5) If the worker has not returned to work, a doctor's estimate of physical capacities should be included with the report. If further information regarding physical capacities is needed or required, a performance-based physical capacities evaluation can be requested. Performance-based physical capacities evaluations should be conducted by a licensed occupational therapist or a licensed physical therapist. Performance-based physical capacities evaluations may also be conducted by other qualified professionals who provided performance-based physical capacities evaluations to the department prior to May 20, 1987, and who have received written approval to continue supplying this service based on formal department review of their qualifications.

Authorization: Notification by a qualified representative of the department or self-insurer that specific medically necessary treatment, services, or equipment provided for the diagnosis and curative or rehabilitative treatment of an accepted condition will be reimbursed by the department or self-insurer.

Average wholesale price (AWP): A pharmacy reimbursement formula by which the pharmacist is reimbursed for the cost of the product plus a mark-up. The AWP is an industry benchmark which is developed independently by companies that specifically monitor drug pricing.

Baseline price (BLP): Is derived by calculating the mean average for all NDC's (National Drug Code) in a specific product group, determining the standard deviation, and calculating a new mean average using all prices within one standard deviation of the original mean average. "Baseline price" is a drug pricing mechanism developed and updated by First Data Bank.

Bundled codes: When a bundled code is covered, payment for them is subsumed by the payment for the codes or services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient. This service is not separately payable because it is included in the payment for other services such as hospital visits.) Bundled codes and services are identified in the fee schedules.

"**By report":** BR (by report) in the value column of the fee schedules indicates that the value of this service is to be determined by report (BR) because the service is too unusual, variable or new to be assigned a unit value. The report shall provide an adequate definition or description of the services or procedures that explain why the services or procedures (e.g., operative, medical, radiological, laboratory, pathology, or other similar service

report) are too unusual, variable, or complex to be assigned a relative value unit, using any of the following as indicated:

(1) Diagnosis;
(2) Size, location and number of lesion(s) or procedure(s) where appropriate;
(3) Surgical procedure(s) and supplementary procedure(s);
(4) Whenever possible, list the nearest similar procedure by number according to the fee schedules;
(5) Estimated follow-up;
(6) Operative time;
(7) Describe in detail any service rendered and billed using an "unlisted" procedure code.

The department or self-insurer may adjust BR procedures when such action is indicated.

Chart notes: This type of documentation may also be referred to as "office" or "progress" notes. Providers must maintain charts and records in order to support and justify the services provided. "Chart" means a compendium of medical records on an individual patient. "Record" means dated reports supporting bills submitted to the department or self-insurer for medical services provided in an office, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service shall be entered in a chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible, and shall include but are not limited to:

(1) Date(s) of service;
(2) Patient's name and date of birth;
(3) Claim number;
(4) Name and title of the person performing the service;
(5) Chief complaint or reason for each visit;
(6) Pertinent medical history;
(7) Pertinent findings on examination;
(8) Medications and/or equipment/supplies prescribed or provided;
(9) Description of treatment (when applicable);
(10) Recommendations for additional treatments, procedures, or consultations;
(11) X-rays, tests, and results; and
(12) Plan of treatment/care/outcome.

Consultation examination report: The following information must be included in this type of report. Additional information may be requested by the department as needed.

(1) A detailed history to establish:
    (a) The type and severity of the industrial injury or occupational disease.
    (b) The patient's previous physical and mental health.
    (c) Any social and emotional factors which may effect recovery.
(2) A comparison history between history provided by attending doctor and injured worker, must be provided with exam.
(3) A detailed physical examination concerning all systems affected by the industrial accident.
(4) A general physical examination sufficient to demonstrate any preexisting impairments of function or concurrent condition.
(5) A complete diagnosis of all pathological conditions including ICD-9-CM codes found to be listed:
    (a) Due solely to injury.
    (b) Preexisting condition aggravated by the injury and the extent of aggravation.
    (c) Other medical conditions neither related to nor aggravated by the injury but which may retard recovery.
    (d) Coexisting disease (arthritis, congenital deformities, heart disease, etc.).
(6) Conclusions must include:
    (a) Type treatment recommended for each pathological condition and the probable duration of treatment.
    (b) Expected degree of recovery from the industrial condition.

(c) Probability, if any, of permanent disability resulting from the industrial condition.
(d) Probability of returning to work.

(7) Reports of necessary, reasonable x-ray and laboratory studies to establish or confirm the diagnosis when indicated.

Doctor: For these rules, means a person licensed to practice one or more of the following professions: Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry.

Only those persons so licensed may sign report of accident forms and time loss cards except as provided in chapter 296-20 WAC.

Emergent hospital admission: Placement of the worker in an acute care hospital for treatment of a work related medical condition of an unforeseen or rapidly progressing nature which if not treated in an inpatient setting, is likely to jeopardize the worker's health or treatment outcome.

Fatal: When the attending doctor has reason to believe a worker has died as a result of an industrial injury or exposure, the doctor should notify the nearest department service location or the self-insurer immediately. Often an autopsy is required by the department or self-insurer. If so, it will be authorized by the service location manager or the self-insurer. Benefits payable include burial stipend and monthly payments to the surviving spouse and/or dependents.

Fee schedules or maximum fee schedule(s): The fee schedules consist of, but are not limited to the following:

(a) Health Care Financing Administration's Common Procedure Coding System Level I and II Codes, descriptions and modifiers that describe medical and other services, supplies and materials.
(b) Codes, descriptions and modifiers developed by the department.
(c) Relative value units (RVUs), calculated or assigned dollar values, percent-of-allowed-charges (POAC), or diagnostic related groups (DRGs), that set the maximum allowable fee for services rendered.
(d) Billing instructions or policies relating to the submission of bills by providers and the payment of bills by the department or self-insurer.
(e) Average wholesale price (AWP), baseline price (BLP), and policies related to the purchase of medications.

Health services provider or provider: For these rules means any person, firm, corporation, partnership, association, agency, institution, or other legal entity providing any kind of services related to the treatment of an industrially injured worker. It includes, but is not limited to, hospitals, medical doctors, dentists, chiropractors, vocational rehabilitation counselors, osteopathic physicians, pharmacists, podiatrists, physical therapists, occupational therapists, massage therapists, psychologists, naturopathic physicians, and durable medical equipment dealers.

Home nursing: Those nursing services that are medically necessary to maintain the worker in their place of temporary or permanent residence consistent with their needs, abilities, and safety. These services may be provided by but are not limited to, home health care, and hospice agencies on either an hourly or intermittent basis.

Independent or separate procedure: Certain of the fee schedule's listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate charge. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated value for "independent procedure" is applicable.

Medical aid rules: The Washington Administrative Codes (WACs) that contain the administrative rules for medical and other services rendered to workers.

Modified work status: The worker is not able to return to their previous work, but is physically capable of carrying out work of a lighter nature. Workers should be urged to return to modified work as soon as reasonable as such work is frequently beneficial for body conditioning and regaining self confidence.
Under RCW 51.32.090, when the employer has modified work available for the worker, the employer must furnish the doctor and the worker with a statement describing the available work in terms that will enable the doctor to relate the physical activities of the job to the worker's physical limitations and capabilities. The doctor shall then determine whether the worker is physically able to perform the work described. The

employer may not increase the physical requirements of the job without requesting the opinion of the doctor as to the worker's ability to perform such additional work. If after a trial period of reemployment the worker is unable to continue with such work, the worker's time loss compensation will be resumed upon certification by the attending doctor.

If the employer has no modified work available, the department should be notified immediately, so vocational assessment can be conducted to determine whether the worker will require assistance in returning to work.

Nonemergent (elective) hospital admission: Placement of the worker in an acute care hospital for medical treatment of an accepted condition which may be safely scheduled in advance without jeopardizing the worker's health or treatment outcome.

Permanent partial disability: Any anatomic or functional abnormality or loss after maximum rehabilitation has been achieved, which is determined to be stable or nonprogressive at the time the evaluation is made. When the attending doctor has reason to believe a permanent impairment exists, the department or self-insurer should be notified.

Specified disabilities (amputation or loss of function of extremities, loss of hearing or vision) are to be rated utilizing a nationally recognized impairment rating guide. Unspecified disabilities (internal injuries, spinal injuries, mental health, etc.) are to be rated utilizing the category system detailed under WAC 296-20-200 et al. for injuries occurring on or after October 1, 1974. **Under Washington law disability awards are based solely on physical or mental impairment due to the accepted injury or conditions without consideration of economic factors**.

Physician: For these rules, means any person licensed to perform one or more of the following professions: Medicine and surgery; or osteopathic medicine and surgery.

Practitioner: For these rules, means any person defined as a "doctor" under these rules, or licensed to practice one or more of the following professions: Audiology; physical therapy; occupational therapy; pharmacy; prosthetics; orthotics; psychology; nursing; physician or osteopathic assistant; and massage therapy.

Proper and necessary:

(1) The department or self-insurer pays for proper and necessary health care services that are related to the diagnosis and treatment of an accepted condition.

(2) Under the Industrial Insurance Act, "proper and necessary" refers to those health care services which are:
   (a) Reflective of accepted standards of good practice, within the scope of practice of the provider's license or certification;
   (b) Curative or rehabilitative. Care must be of a type to cure the effects of a work-related injury or illness, or it must be rehabilitative. Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of an accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Curative and rehabilitative care produce long-term changes;
   (c) Not delivered primarily for the convenience of the claimant, the claimant's attending doctor, or any other provider; and
   (d) Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition.

(3) The department or self-insurer stops payment for health care services once a worker reaches a state of maximum medical improvement. Maximum medical improvement occurs when no fundamental or marked change in an accepted condition can be expected, with or without treatment. Maximum medical improvement may be present though there may be fluctuations in levels of pain and function. A worker's condition may have reached maximum medical improvement though it might be expected to improve or deteriorate with the passage of time. Once a worker's condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary. "Maximum medical improvement" is equivalent to "fixed and stable."

(4) In no case shall services which are inappropriate to the accepted condition or which present hazards in excess of the expected medical benefits be considered proper and necessary. Services that are

controversial, obsolete, investigational or experimental are presumed not to be proper and necessary, and shall be authorized only as provided in WAC 296-20-03002(6) and 296-20-02850.

Regular work status: The injured worker is physically capable of returning to his/her regular work. It is the duty of the attending doctor to notify the worker and the department or self-insurer, as the case may be, of the specific date of release to return to regular work. Compensation will be terminated on the release date. Further treatment can be allowed as requested by the attending doctor if the condition is not stationary and such treatment is needed and otherwise in order.

Temporary partial disability: Partial time loss compensation may be paid when the worker can return to work on a limited basis or return to lesser paying job is necessitated by the accepted injury or condition. The worker must have a reduction in wages of more than five percent before consideration of partial time loss can be made. No partial time loss compensation can be paid after the worker's condition is stationary. **All time loss compensation must be certified by the attending doctor based on objective findings**.

Termination of treatment: When treatment is no longer required and/or the industrial condition is stabilized, a report indicating the date of stabilization should be submitted to the department or self-insurer. This is necessary to initiate closure of the industrial claim. The patient may require continued treatment for conditions not related to the industrial condition; however, financial responsibility for such care must be the patient's.

Total permanent disability: Loss of both legs or arms, or one leg and one arm, total loss of eyesight, paralysis or other condition permanently incapacitating the worker from performing any work at any gainful employment. When the attending

doctor feels a worker may be totally and permanently disabled, the attending doctor should communicate this information immediately to the department or self-insurer. A vocational evaluation and an independent rating of disability may be arranged by the department prior to a determination as to total permanent disability. Coverage for treatment does not usually continue after the date an injured worker is placed on pension.

Total temporary disability: Full-time loss compensation will be paid when the worker is unable to return to any type of reasonably continuous gainful employment as a direct result of an accepted industrial injury or exposure.

Unusual or unlisted procedure: Value of unlisted services or procedures should be substantiated "by report" (BR).

Utilization review: The assessment of a claimant's medical care to assure that it is medically necessary and of good quality. This assessment typically considers the appropriateness of the place of care, level of care, and the duration, frequency or quantity of services provided in relation to the accepted condition being treated.

WAC 296-20-06101 Reporting requirements

What reports are health care providers required to submit to the insurer?

Report	Due/Needed by Insurer	What Information Should Be Included In the Report?	Special Notes
Report of Industrial Injury or Occupational Disease (form) **<u>Self-Insurance</u>: Physician's Initial Report** (form)	Immediately – within 5 days of 1st visit.	See form If additional space is needed, please attach the information to the application. The claim number should be at the top of the page.	Only MD, DO, DC, ND, DPM, DDS, and OD may sign and be paid for completion of this form.
Sixty Day (narrative) ***Purpose***: Support and document the need for continued care when conservative (non-surgical) treatment is to continue beyond sixty (60) days	Every 60 days when only conservative (non-surgical) care has been provided.	1) The ***conditions diagnosed***, including ICD-9-CM codes and the subjective complaints and objective 2) The ***relationship of diagnoses***, if any, to the industrial injury or exposure. 3) Outline of ***proposed treatment program***, its length, components and expected prognosis including an ***estimate of when treatment should be concluded*** and condition(s) stable. An ***estimated return to work date*** and the ***probability***, if any, ***of permanent partial disability*** resulting from the industrial condition. 4) ***Current medications***, including dosage and amount prescribed. With repeated prescriptions, include the plan and need for continuing medication. 5) If the worker has not returned to work, ***indicate whether a vocational assessment will be necessary*** to evaluate the worker's ability to return to work and why. 6) If the worker has not returned to work, a ***doctor's estimate of physical capacities*** should be included.	Providers may submit legible comprehensive chart notes in lieu of 60 day reports **PROVIDED** the chart notes include all the information required as noted in the "What Information Should Be Included?" column. ***However***, office notes are not acceptable in lieu of **requested** narrative reports and providers may not bill for the report if chart notes are submitted in place of the report Please see WAC 296-20-03021 and 296-20-03022 for documentation requirements for those workers

Report (cont.)	Due/Needed by Insurer	What Information Should Be Included In the Report?	Special Notes
		7) ***Response to any specific questions*** asked by the insurer or vocational counselor.	receiving opioids to treat chronic non-cancer pain**.** Providers must **include** their **name**, **address and date** on all chart notes submitted.
Special Reports / Follow-up Reports (narrative)	As soon as possible following request by the department/insurer.	***Response to any specific questions*** asked by the insurer or vocational counselor.	"Special reports" are payable only when requested by the insurer.
Consultation Examination Reports (narrative) ***Purpose***: Obtain an objective evaluation of the need for ongoing conservative medical management of the worker. The attending doctor may choose the consultant.	At 120 days if only conservative (non-surgical) care has been provided.	1) Detailed History 2) **Comparative History** between the history provided by the attending doctor and injured worker. 3) Detailed Physical examination 4) ***Condition(s) diagnosed*** including ICD-9-CM codes, subjective complaints and objective findings. 5) Outline of ***proposed treatment program***: its length, components, expected prognosis including when treatment should be concluded and condition(s) stable. 6) ***Expected degree of recovery*** from the industrial condition. 7) ***Probability of returning to regular work*** *or modified work* and an ***estimated*** return to work ***date***. 8) ***Probability***, if any, of ***permanent partial disability*** resulting from the industrial condition. 9) A doctor's ***estimate of physical capacities*** should be included if the worker has not returned to work. 10) ***Reports*** of necessary, reasonable ***x-ray*** and ***laboratory*** studies to establish or confirm diagnosis when indicated.	**If the injured/ill worker had been seen by the consulting doctor within the past 3 years for the same condition, the consultation will be considered a follow-up office visit, not consultation.** A copy of the consultation report must be submitted to both the attending doctor and the department/ insurer.

Report (cont.)	Due/Needed by Insurer	What Information Should Be Included In the Report?	Special Notes
Supplemental Medical Report (form)	As soon as possible following request by the department/insurer.	See form	Payable only to the attending doctor upon request of the department / insurer.
Attending Doctor Review of IME Report (form) ***Purpose***: Obtain the attending doctor's opinion about the accuracy of the diagnoses and information provided based on the IME.	As soon as possible following request by the department/insurer.	Agreement or disagreement with IME findings. If you disagree, provide objective/subjective findings to support your opinion.	Payable only to the attending doctor upon request of the department / insurer.
Loss of Earning Power (form) ***Purpose***: Certify the loss of earning power is due to the industrial injury/occupational disease.	As soon as possible after receipt of the form.	See form	Payable only to the AP.
Application to Reopen Claim Due to Worsening of Condition (form) ***Purpose*:** Document worsening of the accepted condition and need to reopen claim for additional treatment**.**	Immediately following identification of worsening after a claim has been closed for 60 days. ***Crime Victims***: Following identification of worsening after a claim has been closed for 90 days.	See form	Only MD, DO, DC, ND, DPM, DDS, and OD may sign and be paid for completion of this form.

What documentation is required for initial and follow-up visits?
Legible copies of office or progress notes are required for the initial and all follow-up visits.

What documentation are ancillary providers required to submit to the insurer?
Ancillary providers are required to submit the following documentation to the department or self-insurer:

Provider	Chart Notes	Reports
Audiology	**X**	X
Biofeedback	**X**	X
Dietician		X
Drug & Alcohol Treatment	**X**	X
Free Standing Surgery	**X**	X
Free Standing Emergency Room	**X**	X
Head Injury Program	**X**	X
Home Health Care		X
Infusion Treatment, Professional Services		X
Hospitals	**X**	X
Laboratories		X
Licensed Massage Therapy	**X**	X
Medical Transportation		X
Nurse Case Managers		X
Nursing Home	**X**	X
Occupational Therapist	**X**	X
Optometrist	**X**	X
Pain Clinics	**X**	X
Panel Examinations		X
Physical Therapist	**X**	X
Prosthetist/Orthotist	**X**	X
Radiology		X
Skilled Nursing Facility	**X**	X
Speech Therapist	**X**	X

WAC 296-20-02700 What is a medical coverage decision?

A medical coverage decision is a general policy decision by the director or the director's designee to include or exclude a specific health care service or supply as a covered benefit. These decisions are made to insure quality of care and prompt treatment of workers. Medical coverage decisions include, but are not limited to, decisions on health care services and supplies rendered for the purpose of diagnosis, treatment or prognosis, such as:

- Ancillary services including, but not limited to, home health care services, ambulatory services, specific rehabilitative modalities;
- Devices;
- Diagnostic tests;
- Drugs, biologics, and other therapeutic modalities;
- Durable medical equipment;
- Procedures;
- Prognostic tests; and
- Supplies.

WAC 296-20-02701 Who makes medical coverage decisions?

The director or the director's designee makes medical coverage decisions.

WAC 296-20-02702 Who uses medical coverage decisions?

Self-insured employers and state fund claim managers use medical coverage decisions to help them make claim-specific decisions. For example, the director or director's designee may find that a particular medical device is effective in treating a specific category of injuries. The medical coverage decision might be that that device is a covered benefit for that category of injuries. The self-insured employer or state fund claim manager would make a claim-specific decision to pay or deny payment for that device based on a number of factors, one of which is whether the accepted condition on that claim matches the approved category of injuries in the medical coverage decision.

WAC 296-20-02703 How can I determine if a specific health care service or supply is the subject of a medical coverage decision?

(1) The *Medical Aid Rules*, fee schedules, and provider bulletins and updates specify covered and noncovered services and supplies.

(2) For additional information on existing medical coverage decisions or if you have a question about a new and emerging technology, device, or off-label use of a drug, contact the office of the medical director at:

Department of Labor and Industries
Office of the Medical Director
P.O. Box 44321
Olympia, WA 98504-4321

(3) For questions about what will be authorized on a specific claim, contact the self-insured employer or state fund claim manager.

WAC 296-20-02704 What criteria does the director or director's designee use to make medical coverage decisions?

(1) In making medical coverage decisions, the director or the director's designee considers information from a variety of sources. These sources include, but are not limited to:

- Scientific evidence;
- National and community-based opinions;
- Informal syntheses of provider opinion;
- Experience of the department and other entities;

- Regulatory status.

Because of the unique nature of each health care service, the type, quantity and quality of the information available for review may vary. The director or director's designee weighs the quality of the available evidence in making medical coverage decisions.

(2) Scientific evidence.

(a) "Scientific evidence" includes reports and studies published in peer-reviewed scientific and clinical literature. The director or the director's designee will consider the nature and quality of the study, its methodology and rigorousness of design, as well as the quality of the journal in which the study was published.

- For treatment services, studies addressing safety, efficacy, and effectiveness of the treatment or procedure for its intended use will be considered.
- For diagnostic devices or procedures, studies addressing safety, technical capacity, accuracy or utility of the device or procedure for its intended use will be considered.

(b) The greatest weight will be given to the most rigorously designed studies and on those well-designed studies that are reproducible. The strength of the design will depend on such scientifically accepted methodological

principles as randomization, blinding, appropriateness of outcomes, spectrum of cases and controls, appropriate power to detect differences, magnitude and significance of effect. Additional consideration will be given to those studies that focus on sustained health and functional outcomes of workers with occupational conditions rather than unsustained clinical improvements.

(3) National and community-based opinion.

(a) "National opinion" includes, but is not limited to, syntheses of clinical issues that may take the form of published reports in the scientific literature, national consensus documents, formalized documents addressing standards of practice, practice parameters from professional societies or commissions, and technology assessments produced by independent evidence-based practice centers.

The director or the director's designee will consider the nature and quality of the process used to reach consensus or produce the synthesis of expert opinion. This consideration will include, but may not be limited to, the qualifications of participants, potential biases of sponsoring organizations, the inclusion of graded scientific information in the deliberations, the explicit nature of the document, and the processes used for broader review.

(b) "Community-based opinion" refers to advice and recommendations of formal committees made up of clinical providers within the state of Washington. As appropriate to the subject matter, this may include recommendations from the department's formal advisory committees:

- The industrial insurance and rehabilitation committee of the Washington State Medical Association, which includes a representative from the Washington Osteopathic Medical Association;
- The chiropractic advisory committee.

(4) "Informal syntheses of provider opinion" includes, but is not limited to, professional opinion surveys.

(5) Experience of the department and other entities.

The director or director's designee may consider data from a variety of sources including the department, other state agencies, federal agencies and other insurers regarding studies, experience and practice with past coverage. Examples of these include, but are not limited to, formal outcome studies, cost-benefit analyses, and adverse event, morbidity or mortality data.

(6) Regulatory status.

The director or director's designee will consider related licensing and approval processes of other state and federal regulatory agencies. This includes, but is not limited to:

- The federal food and drug administration's (FDA) regulation of drugs and medical devices (21 U.S.C. 301 et seq. and 21 CFR Chapter 1, Subchapters C, D, & H consistent with the purposes of this chapter, and as now or hereafter amended); and
- The Washington state department of health's regulation of scope of practice and standards of practice for licensed health care professionals regulated under Title 18 RCW.

WAC 296-20-02705 What are treatment and diagnostic guidelines and how are they related to medical coverage decisions?

(1) Treatment and diagnostic guidelines are recommendations for the diagnosis or treatment of accepted conditions. These guidelines are intended to guide providers through the range of the many treatment or diagnostic options available for a particular medical condition. Treatment and diagnostic guidelines are a combination of the best available scientific evidence and a consensus of expert opinion.

(2) The department may develop treatment or diagnostic guidelines to improve outcomes for workers receiving covered health services. As appropriate to the subject matter, the department may develop these guidelines in collaboration with the department's formal advisory committees:

- The industrial insurance and rehabilitation committee of the Washington State Medical Association, which includes a representative from the Washington Osteopathic Medical Association;
- The chiropractic advisory committee.

(3) In the process of implementing these guidelines, the department may find it necessary to make a formal medical coverage decision on one or more of the treatment or diagnostic options. The department, not the advisory committees, is responsible for implementing treatment guidelines and for making coverage decisions that result from such implementation.

WAC 296-20-02850 When may the department cover controversial, obsolete, investigational or experimental treatment?

(1) The department or self-insurer will not authorize nor pay for treatment measures of a controversial, obsolete, investigational or experimental nature. (See WAC 296-20-03002.) Under certain conditions, the director or the director's designee may determine that such treatment is appropriate. In making such a decision, the director or director's designee will consider factors including, but not limited to, the following:

(a) Scientific studies investigating the safety and efficacy of the treatment are incomplete, or if completed, have conflicting conclusions, and:

- Preliminary data indicate the treatment or diagnostic procedure or device has improved net health and functional outcomes; and
- No alternative treatment or diagnostic is available; or

(b) The treatment or diagnostic procedure or device is prescribed as part of:

- A controlled, clinical trial that has been reviewed and approved by an institutional review board that was established in accordance with the federal Department of Health and Human Services (DHHS) regulations (45 CFR Part 46 consistent with the purposes of this chapter, and as now or hereafter amended); and
- For medical devices not yet cleared for marketing, the clinical evaluation has an approved investigational device exemption (IDE) in accordance with the federal Food and Drug Administration (FDA) regulations (21 CFR Parts 50, 56, and 812 consistent with the purposes of this chapter, and as now or hereafter amended); and

- For drugs not yet cleared for marketing, the clinical evaluation has been approved in accordance with the federal Food and Drug Administration (FDA) regulations (21 CFR Part 312 consistent with the purposes of this chapter, and as now or hereafter amended); or

(c) The usually indicated procedure or diagnostic test would likely be harmful for the patient because of other unrelated conditions.

(2) The health care provider must submit a written request and obtain approval from the department or self-insurer, prior to using a controversial, obsolete, investigational, or experimental treatment. The written requests must contain a description of the treatment, the reason for the request, potential risks and expected benefits, length of care and estimated cost of treatment.

WAC 296-20-030 Treatment not requiring authorization for accepted conditions

(1) A maximum of twenty office calls for the treatment of the industrial condition, during the first sixty days, following injury. Subsequent office calls must be authorized. Reports of treatment rendered must be filed at sixty day intervals to include number of office visits to date. See chapter 296-20 WAC and department policies for report requirements and further information.

(2) Initial diagnostic x-rays necessary for evaluation and treatment of the industrial injury or condition. See WAC 296-20-121 for further information.

(3) The first twelve physical therapy treatments as provided by chapters 296-21, 296-23, and 296-23A WAC, upon consultation by the attending doctor or under his direct supervision. Additional physical therapy treatment must be authorized and the request substantiated by evidence of improvement. In no case will the department or self-insurer pay for inpatient hospitalization of a claimant to receive physical therapy treatment only. USE OF DIAPULSE, THERMATIC (standard model only), SPECTROWAVE AND SUPERPULSE MACHINES AND IONTOPHORESIS IS NOT AUTHORIZED FOR WORKERS ENTITLED TO BENEFITS UNDER THE INDUSTRIAL INSURANCE ACT.

(4) Routine laboratory studies reasonably necessary for diagnosis and/or treatment of the industrial condition. Other special laboratory studies require authorization.

(5) Routine standard treatment measures rendered on an emergency basis or in connection with minor injuries not otherwise requiring authorization.

(6) Consultation with specialist when indicated. See WAC 296-20-051 for consultation guidelines.

~~(7) Nonscheduled drugs and medications during the acute phase of treatment for the industrial injury or condition.~~

~~(8) Scheduled drugs and other medications known to be addictive, habit forming or dependency inducing may be prescribed in quantities sufficient for treatment for a maximum of twenty-one days. If drug therapy extends beyond thirty days, see WAC 296-20-03003 regarding management.~~

~~(9) Injectable scheduled and other drugs known to be addictive, habit forming, or dependency inducing may be provided only on an in-patient basis. Hospital admission for administration of drugs for relief of chronic pain only will not be allowed.~~

(7) Diagnostic or therapeutic nerve blocks. See WAC 296-20-03001 for restrictions.

(8) Intra-articular injections. See WAC 296-20-03001 for restrictions.

(9) Myelogram if prior to emergency surgery.

WAC 296-20-03003 Drugs and medication

Repealed

WAC 296-20-03010 What are the general principles the department uses to determine coverage on drugs and medications?

The department or self-insurer pays for drugs that are deemed proper and necessary to treat the industrial injury or occupational disease accepted under the claim. In general, the department will consider coverage for all FDA approved drugs for stated indications. The department or self-insurer may pay for prescriptions for off label indications when used within current medical standards and prescribed in compliance with published contraindications, precautions and warnings.

WAC 296-20-03011 What general limitations are in place for medications?

(1) **Amount dispensed.** The department or self-insurer will pay for no more than a thirty-day supply of a medication dispensed at any one time.

(2) **Over-the-counter drugs.** Prescriptions for over-the-counter items may be paid. Special compounding fees for over-the-counter items are not payable.

(3) **Generic drugs.** Prescriptions are to be written for generic drugs unless the attending physician specifically indicates that substitution is not permitted. For example: The patient cannot tolerate substitution. Pharmacists are instructed to fill with generic drugs unless the attending physician specifically indicates substitution is not permitted.

(4) **Prescriptions for unrelated medical conditions.** The department or self-insurer may consider temporary coverage of prescriptions for conditions not related to the industrial injury when such conditions are retarding recovery. Any treatment for such conditions must have prior authorization per WAC 296-20-055.

(5) **Pension cases.** Once the worker is placed on a pension, the department or self-insurer may pay for only those drugs and medications authorized for continued medical treatment for conditions previously accepted by the department. Authorization for continued medical and surgical treatment is at the sole discretion of the supervisor of industrial insurance and must be authorized before the treatment is rendered. In such pension cases, the department or self-insurer cannot pay for scheduled drugs used to treat continuing pain resulting from an industrial injury or occupational disease.

WAC 296-20-03012 Where can I find the department's outpatient drug and medication coverage decisions?

The department's outpatient drug and medication coverage decisions are contained in the department's formulary, as developed by the department in collaboration with the Washington State Medical Association's Industrial Insurance and Rehabilitation Committee.

In the formulary, drugs are listed in the following categories:

- **Allowed**

  Drugs used routinely for treating accepted industrial injuries and occupational illnesses.

  Example: Nonscheduled drugs and other medications during the acute phase of treatment for the industrial injury or condition.

- **Prior authorization required**

  Drugs used routinely to treat conditions not normally accepted as work related injuries, drugs which are used to treat unrelated conditions retarding recovery from the accepted condition on the claim, and drugs for which less expensive alternatives exist.

  Example: All drugs to treat hypertension because hypertension is not normally an accepted industrial condition.

- **Denied**

  Drugs not normally used for treating industrial injuries or not normally dispensed by outpatient pharmacies.

  Example: Most hormones, most nutritional supplements.

WAC 296-20-03013 Will the department or self-insurer pay for a denied outpatient drug in special circumstances?

Some of the drugs that are routinely denied may be covered in special circumstances. Requests for coverage under special circumstances require authorization prior to treatment. Examples of drugs that may be covered in special circumstances include:

- Drugs and medications to treat unrelated conditions when retarding recovery;
- Special treatments for unique catastrophic injuries.

The department may require written documentation to support the request.

WAC 296-20-03014 Which drugs have specific limitations?

(1) **Injectables.** Prescriptions for injectable opioids or other analgesics, sedatives, antihistamines, tranquilizers, psychotropics, vitamins, minerals, food supplements, and hormones are not covered.

Exceptions: The department or self-insurer covers injectable medications under the following circumstances.

(a) Indicated injectable drugs for the following:
- Inpatients; or
- During emergency treatment of a life-threatening condition/injury; or
- During outpatient treatment of severe soft tissue injuries, burns or fractures when needed for dressing or cast changes; or
- During the perioperative period and the postoperative period, not to exceed forty-eight hours from the time of discharge.

(b) Prescriptions of injectable insulin, heparin, anti-migraine medications, or impotency treatment, when proper and necessary.

(2) **Noninjectable scheduled drugs administered by other than the oral route.** Nonoral routes of administration of scheduled drugs that result in systemic availability of the drug equivalent to injectable routes will also not be covered.

(3) **Sedative-hypnotics.** During the chronic stage of an industrial injury or occupational disease, payment for scheduled sedatives and hypnotics will not be authorized.

(4) **Benzodiazepines.** Payment for prescriptions for benzodiazepines are limited to the following types of patients:
- Hospitalized patients;
- Claimants with an accepted psychiatric disorder for which benzodiazepines are indicated;
- Claimants with an unrelated psychiatric disorder that is retarding recovery but which the department or self-insurer has temporarily authorized treatment (see WAC 296-20-055) and for which benzodiazepines are indicated; and
- Other outpatients for not more than thirty days for the life of the claim.

(5) Cancer. When cancer or any other end-stage disease is an accepted condition, the department or self-insurer may authorize payment for any indicated scheduled drug and by any indicated route of administration.

(6) Spinal cord injuries. When a spinal cord injury is an accepted condition, the department or self-insurer may authorize payment for anti-spasticity medications by any indicated route of administration (e.g., some benzodiazepines, Baclofen). Prior authorization is required.

Note: See the department formulary for specific limitations and prior authorization requirements of other drugs.

WAC 296-20-03015 What steps may the department or self-insurer take when concerned about the amount or appropriateness of drugs and medications prescribed to the injured worker?

(1) The department or self-insurer may take any or all of the following steps when concerned about the amount or appropriateness of drugs the patient is receiving:
- Notify the attending physician of concerns regarding the medications such as drug interactions, adverse reactions, prescriptions by other providers;
- Require that the attending physician send a treatment plan addressing the drug concerns;
- Request a consultation from an appropriate specialist;
- Request that the attending physician consider reducing the prescription, and provide information on chemical dependency programs;
- Limit payment for drugs on a claim to one prescribing doctor.

(2) If the attending physician or worker does not comply with these requests, or if the probability of imminent harm to the worker is high, the department or self-insurer may discontinue payment for the drug after adequate prior notification has been given to the worker, pharmacy and physician.

(3) Physician failure to reduce or terminate prescription of controlled substances, habit forming or addicting medications, or dependency inducing medications, after department or self-insurer request to do so for an injured worker may result in a transfer of the worker to another physician of the worker's choice. (See WAC 296-20-065.)

(4) Other corrective actions may be taken in accordance with WAC 296-20-015, Who may treat.

WAC 296-20-03016 Is detoxification and/or chemical dependency treatment covered?

The department or self-insurer may pay for detoxification and/or chemical dependency treatment in the following circumstances:

- The injured worker becomes dependent or toxic on medication prescribed for an accepted condition on the claim; or
- The injured worker becomes dependent or toxic due to medications prescribed for a condition retarding recovery of the accepted condition on the claim; or
- The injured worker is dependent or toxic due to medications for an unrelated condition, but that dependency or toxicity is retarding recovery of the accepted condition.

WAC 296-20-03017 What information is needed for prescriptions and the physician's record?

Prescriptions must include the department authorized provider number for the prescribing physician and the physician's signature. The physician's record must contain the name and reason for the medication, the dosage, quantity prescribed and/or dispensed, the route of administration, the frequency, the starting and stopping dates, the expected outcome of treatment, and any adverse effects that occur. Please refer to WAC 296-20-03021 and 296-20-03022 for additional documentation requirements when treating chronic, noncancer pain.

WAC 296-20-03018 What inpatient drugs are covered?

In general, the department or self-insured employer pays for most drugs in an inpatient hospital setting. Please see WAC 296-20-075, Hospitalization.

WAC 296-20-03019 Under what conditions will the department or self-insurer pay for oral opioid treatment for chronic, noncancer pain?

Chronic, noncancer pain may develop after an acute injury episode. It is defined as pain that typically persists beyond two to four months following the injury.

The department or self-insurer may pay for oral opioids for the treatment of chronic, noncancer pain caused by an accepted condition when that treatment is proper and necessary. See WAC 296-20-01002 for the definition of "proper and necessary" health care services.

WAC 296-20-03020 What are the authorization requirements for treatment of chronic, noncancer pain with opioids?

No later than thirty days after the attending physician begins treating the worker with opioids for chronic, noncancer pain, the attending physician must submit a written report to the department or self-insurer in order for the department or self-insurer to pay for such treatment. The written report must include the following:

- A treatment plan with time-limited goals;
- A consideration of relevant prior medical history;
- A summary of conservative care rendered to the worker that focused on reactivation and return to work;
- A statement on why prior or alternative conservative measures may have failed or are not appropriate as sole treatment;

- A summary of any consultations that have been obtained, particularly those that have addressed factors that may be barriers to recovery;
- A statement that the attending physician has conducted appropriate screening for factors that may significantly increase the risk of abuse or adverse outcomes (e.g., a history of alcohol or other substance abuse); and
- An opioid treatment agreement that has been signed by the worker and the attending physician. This agreement must be renewed every six months. The treatment agreement must outline the risks and benefits of opioid use, the conditions under which opioids will be prescribed, the physician's need to document overall improvement in pain and function, and the worker's responsibilities.

WAC 296-20-03021 What documentation is required to be submitted for continued coverage of opioids to treat chronic, noncancer pain?

In addition to the general documentation required by the department or self-insurer, the attending physician must submit the following information at least every sixty days when treating with opioids:

- Documentation of drug screenings, consultations, and all other treatment trials;
- Documentation of outcomes and responses, including pain intensity and functional levels; and
- Any modifications to the treatment plan.

The physician must use a form developed by the department, or a substantially equivalent form, to document the patient's improvement in pain intensity and functional levels. This form may be included as part of a sixty-day report.

WAC 296-20-03022 How long will the department or self-insurer continue to pay for opioids to treat chronic, noncancer pain?

The department or self-insurer will continue to pay for treatment with opioids so long as the physician documents:

- Substantial reduction of the patient's pain intensity; and
- Continuing substantial improvement in the patient's function.

Once the worker's condition has reached maximum medical improvement, further treatment with opioids is not payable. Opioid treatment for chronic, noncancer pain past the first three months of such treatment without documentation of substantial improvement is presumed to be not proper and necessary.

WAC 296-20-03023 When may the department or self-insurer deny payment of opioid medications used to treat chronic, noncancer pain?

Payment for opioid medications may be denied in any of the following circumstances:

- Absent or inadequate documentation;
- Noncompliance with the treatment plan;
- Pain and functional status have not substantially improved after three months of opioid treatment; or
- Evidence of misuse or abuse of the opioid medication or other drugs, or noncompliance with the attending physician's request for a drug screen.

WAC 296-20-03024 Will the department or self-insurer pay for nonopioid medications for the treatment of chronic, noncancer pain?

The department or self-insurer may pay for nonopioid medication for the treatment of chronic, noncancer pain when it is proper and necessary.

For example, some drugs such as anti-convulsants, anti-depressants, and others have been demonstrated to be useful in the treatment of chronic pain and may be approved when proper and necessary.